

Appendix 7

Completed Sample Prior Authorization Request Form (PA/RF), Prior Approval Granted

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # **1223334**

1 PROCESSING TYPE

132

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER

1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

Recipient, Ima A.

5 DATE OF BIRTH

MM/DD/YYYY

6 SEX

M ☐

F ☒

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

**609 Willow
Anytown, WI 55555**

8 BILLING PROVIDER TELEPHONE NUMBER

(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:

**I.M. Provider
1 W. Williams
Anytown, WI 55555**

9 BILLING PROVIDER NO.

12345678

10 DX: PRIMARY

250.01 Diabetes

11 DX: SECONDARY

595.9 Cystitis

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
A4253		4	9	Blood glucose test strips	3	XXX.XX
A4259		4	9	Lancets	2	XXX.XX

22. An approved authorization does not guarantee payment.

Reimbursement is contingent upon eligibility of the

recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL
CHARGE

21 **XXX.XX**

23 **MM/DD/YYYY**
DATE

24 **I.M. Provider**
REQUESTING PROVIDER SIGNATURE

start date: **01-01-01**
end date: **03-31-01**

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☒
APPROVED

☐
MODIFIED

☐
DENIED

☐
RETURN

REASON:

REASON:

REASON:

01-01-01

GRANT DATE

03-31-01

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

**A4253
A4259**

QUANTITY AUTHORIZED

**9
5**

12/27/00

DATE

J.M. Jones Consultant

CONSULTANT/ANALYST SIGNATURE